VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Clinical Utilization Review Board (CURB)
May 19, 2021

PRESENT:

Board: Thomas Connolly, DMD; Joshua Green, ND; Nels Kloster, MD; John Matthew, MD; Elizabeth Newman, MD; Michael Rapaport, MD

DVHA Staff: Katie Collette, RN, Clinical Operations Unit Nurse Case Manager; Christine Ryan, RN, Clinical Operations Unit Nursing Operations Director; Scott Strenio, MD DVHA Chief Medical Officer, CURB meeting facilitator; Sandi Hoffman, MSW, LADC, Deputy Commissioner

Absent: Valerie Riss, MD

Handouts:
Materials attached to the meeting invite included:

- Minutes from November 18t, 2020; January 20, 2021; March 17, 2021
- Agenda for the May 19, 2021 meeting
- PT/OT/ST Proposal to the CURB

CONVENE: Dr. Scott Strenio convened the meeting at 6:40 pm.

1.0 Introductions and Acknowledgments

Dr. Strenio welcomed all to the meeting and facilitated introductions of DVHA staff, Board members, and additional attendees.

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2.0 Review and Approval of Minutes

Minutes were reviewed from the following meeting dates:

- November 18th, 2020
- January 20th, 2021
- March 17th, 2021

All minutes were reviewed and approved as written.

3.0 Old Business

Dr. Strenio reviewed that DVHA is moving forward with discontinuing prior authorization requirement for high-tech imaging as was supported by the CURB via a vote taken at the end of March 2021. The contract with the vendor that completes prior authorization for DVHA, eviCore, will end at the end of May 2021. Factors contributing to this change included 1) the vast population of Vermont Medicaid members are currently attributed to the ACO and prior authorization for high-tech imaging is not required for ACO members; 2) the Legislature is currently asking payers to assess services for which prior auth is required in order to identify areas where use of this utilization management tool may no longer be efficacious; 3) overutilization of high-tech imaging has not been pointedly studied or identified in Vermont.

4.0 **New Business**

Out-of-Network – Dr. Scott Strenio

DVHA has identified an increase in out-of-network service utilization over the past several years. An internal workgroup at DVHA has been discussing out-of-network service utilization as part of the groups' larger efforts to examine services requiring prior authorization. Recent discussions have been focused on reviewing specific causal indicators for the increased out-of-network service utilization. Dr. Strenio discussed that there may be some instances, such as referrals to specific facilities, e.g. Boston Children's Hospital, that are entirely appropriate because these pediatric specialists are not available in-network. There is concern that providers and members have been referring or self-referring to out-of-network specialists/services related to preference. The issues associated with seeking out-of-network services when they are available in-network include increased associated costs (transportation and lodging), challenges related to care coordination and transitions of care, and provider retention in-network. Commercial payers have more rigid requirements around out-of-network service requests. Dr. Strenio asked the Board members to weigh in on data that they feel may inform future out-of-network service utilization oversight to ensure appropriate use of resources. He also asked for comments from experience with out-of-network referrals. Christine added that DVHA would like the input of Board members regarding methodology and considerations for referrals out-of-network as providers in the community.

One Board member discussed his experience with what used to be the state supported Children with Special Health Needs Craniofacial program, now run by UVMMC. He reported that residents and providers at the clinic were not specifically educated regarding parameters related to out-of-network referral and that while it was often assumed that the complex cases that required specialty services beyond what was available in the clinic would end up in Boston, there was no foreknowledge or control in where the patients decided to go. The Board member noted that it may be valuable to review claims data to identify if there are diagnostic codes that are regularly submitted that may aid in discerning self-referral due to convenience versus medical necessity. He noted it was unclear who was making the determinations that a specific specialist Are we seeing the effect of a lack of specialties here in Vermont?

Dr. Strenio described that DVHA is reviewing claims data to help identify if there are geographical patterns associated with out-of-network service utilization. He also discussed that this past year has provided an opportunity for expanded telehealth use and perhaps we can use what we have learned about telehealth over that last year as a tool in considering out-of-network service oversight.

Another Board member recounted that when he worked in family medicine, his experience around out-of-network referrals were often related to malignancy diagnoses and the patient's desire for a second opinion at a facility renowned for cancer treatment such as Dana Farber, Sloan Kettering, etc. He noted while there no fault for a patient to

seek out what they perceive to be the best care, it is difficult when the course of treatment would not differ from that offered in-network.

One Board member asked about out-of-network services and the Vermont Medicaid fee schedule. Dr. Strenio reviewed that even when the out-of-network provider accepts the fee schedule rate, there are often ancillary costs to out-of-network services such as transportation and lodging. Dr. Strenio discussed the second opinion policy was reviewed recently and it was emphasized that if there was another provider available in-network and the member was able to be seen in a reasonable length of time, the second opinion should still remain in-network. Thus the second opinion policy did not entitle members the ability to seek a second opinion at any service provider of their choosing

The same Board member discussed that there are some unusual diagnoses for which it may be helpful to maintain a list of providers available in-network that treat such conditions. Dr. Strenio affirmed this and noted challenges of maintaining such a list may be cumbersome due to providers coming and going. He reported that when seeking to identify specialty availability, he utilized the approach of outreaching the medical officers at the tertiary facilities in-network for assistance.

Another Board member reviewed instances when individuals move to Vermont from out of state and previously had relationships with an out-of-network provider, facility, or specialist. She review there might be an opportunity to bridge this population into network if care for the condition is available in-network. She also discussed that there may be some cost savings when members with rare conditions obtain services out-of-network at specialty care centers such as Boston Children's where the patient can be seen by multiple specialists in one visit. She added further that she felt there was a need for review of such requests to see providers at specialty care centers and questioned the current requirements. It was reviewed with the Board members that out-of-network office visits do require prior authorization for Vermont Medicaid members unless the member is ACO attributed, in which case, the ACO does not require prior authorization for office visits.

Dr. Strenio reviewed that providers out-of-network do need to enroll with Vermont Medicaid to be paid via the fee schedule however there are situations where DVHA forms agreements with facilities for enhanced reimbursement rates due to the essential need for the service when not available in-network. Dr. Strenio further reviewed that through the contract that Vermont Medicaid has with the OneCare ACO, prior auth is waived for many services as incentive to participate. The foundation of the ACO is that if the providers work well together to manage care then if there is money left over from the year from the total cost of care contract, it is shared among the ACO providers. Sandi Hoffman added each year, budgets for total cost of care are determined based upon past years total cost of care. A Board member asked if this implied that indirectly DVHA has some risk for reconciling the budget when these things occur going forward. Sandi confirmed that there could be budgetary risk to DVHA because the total cost of care paid to OneCare by Vermont Medicaid per member is based upon past years spend.

Thus, if there is a large increase in any area of spend, this can impact the per member total cost of care for future budgets.

Another Board member noted that even the most basic piece of information about health and health cost savings is not promulgated anywhere unless you stumble upon it in a medical publication. He added that there needs to be some sort of mechanism for exchanging prevention and best practices information that would then help drive down overall cost of care. He stated that it would be in Medicaid's best interest to inform people in this way. Dr. Strenio noted that at current there is much discussion and work going on to identify responsibilities within the partnership between OneCare and DVHA. He added that spreading best practices and scaling efficiencies is in everyone's best interest however OneCare has the greatest risk in the partnership and DVHA is working to be supportive of the ACO and provide as much feedback as possible.

One member discussed that small practices are not able to participate in the shared savings benefit with OneCare. He noted that one of the problems with OneCare from a political standpoint is the tremendous cost to certain providers to participate in OneCare and the lack of shared savings benefit to physicians in small practices. He also commented that the service rates that OneCare Vermont pays hospital-based providers is much greater than those paid to small independent practice physicians. He asked what the current requirements are around out-of-network requests for services. Dr. Strenio reviewed DVHA does ask for indication and supporting clinical documentation for going out-of-network as part of the prior authorization process for out-of-network office visits. He also discussed that he is able to outreach UVMMC and DHMC chief medical officers to identify if there is an appropriate specialist in-network. If for example, the reason for the referral is because it is closer to go to Boston than UVM, we will ask if they considered telemedicine first.

PT/OT/ST Prior Authorization Proposal – Christine Ryan

DVHA has been engaged in reviewing services that currently require prior authorization to identify areas where requirement of such may no longer be effective. Reasons for this work include 1) addressing legislative bill H.960 to compile a report for September to identify services for which prior auth may no longer be efficacious and 2) aligning clinical and payment methodologies between the ACO versus non-ACO attributed population. A designated group of clinicians within DVHA have been involved in code review and prior auth requirement determinations.

As part of this work, a proposal for a change in prior auth requirements for physical therapy (PT), occupational therapy (OT). and speech therapy (ST) services was developed by DVHA and presented to the Board members seeking feedback. The recommendations of the proposal include 1) to continue prior auth requirements for PT/OT/ST for adults after 30 visits and 2) to change the prior auth requirement for PT/OT/ST for pediatric members from after 8 visits to after 30 visits and make this consistent for both ACO and non-ACO attributed members. Decision points for the proposal included 1) currently all Medicaid payments for PT/OT/ST services are fee for

service, 2) Vermont Medicaid prior auth requirements for PT/OT/ST aligns w/ BCBS, 3) proposing a change by extending the prior auth requirements to the entire pediatric Medicaid versus different requirements based on attribution as the ACO currently does not require prior auth for pediatric PT/OT/ST, and 4) increasing the pediatric PT/OT/ST requirement to 30 visits from 8 visits.

One board member asked if the requirements by Vermont Medicaid as they exist today, are in place for children with developmental delays and chronic illnesses who are seeing PT/OT/ST in the schools several days per week. Christine confirmed these requirements are in place regardless of clinical indication. Another Board member asked if there was a projection of how much more this will cost Vermont Medicaid. He additionally asked, are there currently more pediatric patients on standard Medicaid than in the ACO that receive these services? Sandi noted that these services are fee for service whether the member is ACO attributed or not. All members are a part of Medicaid. This change would be budget neutral because there would be no change in service volumes. There could be more services provided without oversight for pediatric members because the number of visits allowed before prior auth would increase from 8 to 30. At current, unlike the ACO attributed members who can receive unlimited services with no oversight, there would now be a requirement for prior authorization after 30 visits. Katie Collette added that ACO attribution methodology is not based on clinical complexity of a member. Sandi confirmed that this is not criteria that determines whether a member is ACO attributed or not. Christine added that the majority of complex pediatric cases are already under Medicaid and ACO umbrella because the majority of Medicaid members are attributed to the ACO. This proposal suggests the same approach for the adult and pediatric population.

The same Board member asked if there enough of a sample to look at clinical outcomes of members who have received 8 PT/OT/ST services versus 30 and if there's improvement for the members. Another Board member asked why there has been such a difference between adult and pediatric PT/OT/ST service limits historically and is this change being made due to pressure to align what we are doing with what everyone else is doing? Christine discussed that DVHA is certainly considering what other payers are doing, the advent of the ACO, the reduction of administrative burden and what these outcomes mean for our members. DVHA recognizes the pediatric population as a more vulnerable population. Other payers have aligned adult and pediatric prior auth requirements. Sandi added that it is a legislative mandate that DVHA look for opportunities to reduce the administrative burden of prior authorization. Therefore DVHA is examining the different services for which prior authorization is required, looking at the data related to the service utilization, comparing what other payers are doing, and looking at the history and best practices to create a recommendation.

Dr. Strenio noted to the CURB that this is a proposal that DVHA is recommending to the Board to consider and asked the Board to participate in a vote to support the proposal. Christine concluded the conversation noting DVHA recognizes that this is a change and it will require regular review of utilization data and clinical findings. She emphasized that this is a decision that DVHA will want to follow and track. DVHA

would like to work with and educate the provider community to ensure the best clinical outcomes for our members. The Board voted and unanimously approved to support the DVHA proposal for changes to requirements for PT/OT/ST services.

5.0 **Closing**

Comments

A Board member discussed historical data resources such as the Blueprint for Health and the Uniform Data System that outline for provider how they are comparing to other providers caring for their respective patient population. He added that it would be beneficial to look at this information more critically and in a more innovative way. Christine discussed that evaluation of the telemedicine data is forthcoming, looking at how that relates to the communities, the providers and the geographic regions that have high utilization of telemedicine and how does that relate to the utilization of the ED. The same Board member noted that the upside of telemedicine is that people don't have to miss work, they don't have to drive to the offices, they can switch around their appointments more easily. The downside is that there are specific conditions that have had some disparities, e.g. hypertension. He added, we should try to come up with ideas to compensate for these things.

Another Board member emphasized that it would be appreciated if we could discuss with OneCare, allowing small practices to participate in the shared savings benefits for equity. Sandi reported she will be bringing that back to OneCare to be discussed.

Sandi reported that there is currently a DVHA Policy Benefit and Reimbursement (PBR) form circulating at DVHA for blood pressure set ups. DVHA's current performance improvement project is looking to identify interventions to improve blood pressure control in the Vermont Medicaid population and one of the recommendations for prevention is supplying blood pressure set up to members more readily. Christine noted that there would be future updates related to the performance improvement project around blood pressure control.

Adjournment – CURB meeting adjourned at 8:12 PM

Next Meeting

July 21, 2021
Time: 6:30 PM – 8:30 PM
Location: Teams or update TBD